

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-025125

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6626**

FILED JUL 12 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Pine Lawn	
Length of stay in lb 10 Days		Inside Limits Yes No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS (If outside, give location) 6287 Creston	
Inside Limits Yes No <input type="checkbox"/>		Reside on Farm Yes No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last FRANCIS ALOYSIUS RUCKMAN			4. DATE OF DEATH Month Day Year July 4, 1962		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/27/1899	9. AGE (last birthday) 62	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paint Sprayer		10b. KIND OF BUSINESS OR INDUSTRY Motor Car Mfg.		11. BIRTHPLACE (City and state or country) St. Charles, Mo.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME John Ruckman		13b. MOTHER'S MAIDEN NAME Katherine Cloonan	
14. NAME OF HUSBAND OR WIFE Frances Rice		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. #1		16. SOCIAL SECURITY NO. 6287 Creston	
17. INFORMANT Frances Ruckman		Address 6287 Creston			

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Disease DUE TO (b) BRONCHOGENIC CARCINOMA DUE TO (c) 162.1		INTERVAL BETWEEN ONSET AND DEATH 7 Mos 2 yrs
--	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) myocardial Failure		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
--	--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	---	--

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	--	--

21. I attended the deceased from 1960 to JULY 4, 1962 and last saw him alive on JULY 4, 1962 Death occurred at 11:12 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Leonard L. Piccone M.D.	22b. ADDRESS 6303 Natural Bridge Mo.	22c. DATE SIGNED 7-5-62
--	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7/7/62	23c. NAME OF CEMETERY OR CREMATORY St. Chas. Borromeo	23d. LOCATION (City, town, or county) (State) St. Charles Mo.
---	----------------------------	---	---

24. FUNERAL DIRECTOR Cullen Kelly	25. DATE RECD. BY LOCAL REG. JUL 5 1962	26. REGISTRAR'S SIGNATURE Neal Smith M.D.
---	---	---

27. ADDRESS 7267 Natural Bridge

USE BLACK INK

OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

BY AFFIDAVIT OF

DOCUMENT

DATE AMENDED

VS 300
Rev. 4/59

1

3

4

5

6

7

8

9

10

11

12

13

59

59

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

James A. Hammer

Licensed Embalmer No.

4142

P. O. Address

St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.